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FAMILY CAREGIVERS' EXPERIENCES OF DEVELOPING RESILIENCE WHILE CARING FOR A FAMILY MEMBER WITH HYPERTENSION: A DESCRIPTIVE PHENOMENOLOGICAL STUDY

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ABSTRACT

Hypertension requires sustained caregiving to support medication management, lifestyle modification, blood pressure monitoring, and access to healthcare services. However, limited evidence explains how family caregivers develop resilience through the demands of long-term hypertension care. This study aimed to explore family caregivers' experiences of developing resilience while caring for a family member with hypertension. A descriptive phenomenological study was conducted in the service area of Margadadi Community Health Center, Indramayu Regency, Indonesia, from May to August 2026. Eleven family caregivers, each representing a different patient with hypertension, were recruited through purposive sampling. Data were collected through face-to-face, in-depth interviews and follow-up validation and were analyzed using Colaizzi's method. Four themes emerged: reorganizing care in response to hypertension-related threats; sustaining care amid social and environmental pressures; transforming affection into adaptive caregiving commitment; and maintaining continuity of care through flexible yet unequal family contributions. Caregiver resilience developed through an ongoing process of recognizing threats, modifying care, negotiating external pressures, sustaining meaningful routines, mobilizing available support, and continuing caregiving despite emotional and role-related burdens. These findings highlight resilience as a dynamic adaptive process rather than a collection of caregiving behaviors or a fixed personal characteristic. The findings underscore the importance of strengthening caregivers' adaptive capacity, supporting realistic role distribution, and recognizing the burden borne by primary caregivers within community-based hypertension care.

Keywords: community nursing; family caregiving; family resilience; hypertension; phenomenology

INTRODUCTION

Hypertension remains a major public health challenge because it often develops without distinctive symptoms while progressively damaging the heart, brain, kidneys, and blood vessels. In 2024, approximately 1.4 billion adults aged 30–79 years were living with hypertension worldwide, two-thirds of whom were in low- and middle-

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income countries. Only slightly more than 20% had achieved blood pressure control, indicating that treatment availability has not been matched by the capacity to sustain hypertension management in daily life (World Health Organization, 2025).

Indonesia faces a similar challenge. An analysis of three national health surveys showed that the crude prevalence of adult hypertension increased from 27.9% in 2013 to 31.6% in 2023, while only 26.9% of people with hypertension had been diagnosed in 2023 (Muharram et al., 2025). Dietary patterns characterized by high salt, fat, and sugar intake also continue to contribute to hypertension across Indonesian regions (Yanti et al., 2025). Hypertension control therefore requires more than clinical treatment; it depends on sustained changes within everyday living environments, particularly the family.

Long-term hypertension care involves medication adherence, dietary modification, physical activity, stress management, health examinations, and blood pressure monitoring. These practices may be difficult to sustain when patients are asymptomatic, experience medication side effects, face financial constraints, or have limited understanding of disease-related risks. Patients' experiences of hypertension management are influenced by illness acceptance, health literacy, stress management, access to care, and family support (Endrias et al., 2024). Similarly, medication adherence is facilitated by disease acceptance, health monitoring, healthy lifestyle practices, and support from families and healthcare professionals (Ghaderi Nasab et al., 2024). These findings position the family as an integral part of hypertension management.

Family involvement includes preparing healthier meals, providing medication reminders, accompanying patients to healthcare appointments, monitoring blood pressure, offering emotional support, and participating in decisions. These are caregiving behaviors, but they do not in themselves demonstrate resilience. Resilience becomes evident when caregivers adapt these actions in response to stress, reorganize roles and resources, and sustain caregiving functions despite disruption. In Indonesia, a family self-management program improved blood pressure management and adherence to sodium restriction (Susanto et al., 2024), while a patient-family partnership intervention improved blood pressure, self-care, dyadic relationship quality, anxiety, and quality of life (Zeng et al., 2024). Such evidence establishes the value of family involvement but does not explain how adaptive caregiving capacity develops through everyday experience.

The demands of hypertension caregiving can simultaneously function as sources of stress and as experiences through which caregivers develop adaptive capacity. Changes in routines, responsibilities, household expenditure, dietary practices, and communication may create tension, particularly when patients resist medication reminders or lifestyle restrictions. Caregiver strain among families caring for older adults with chronic illness is associated with resilience and psychological hardiness (Sorayyanezhad et al., 2022), while qualitative evidence shows that chronic illness caregiving produces physical, psychological, social, and financial burdens even as caregivers develop meaning and acceptance (Yustisia et al., 2023).



In this study, caregiver resilience was theoretically understood as a dynamic process of positive adaptation through which a family caregiver recognizes caregiving stressors, mobilizes internal and external resources, modifies caregiving strategies, and maintains meaningful care despite adversity. Its operational indicators included learning from illness-related threats, reorganizing physical and emotional care, negotiating environmental pressures, sustaining health-related routines, seeking healthcare support, and adjusting contributions when caregiving resources were limited. This definition distinguishes resilience from coping, which refers to specific responses used to manage stress, and from adaptation, which refers to the changes resulting from those responses. Resilience is reflected in the sustained process through which coping and adaptation preserve caregiving function over time (Kuang et al., 2023).

Current hypertension research predominantly addresses prevalence, risk factors, self-care, medication adherence, family support, and family-based interventions. Qualitative studies have generally examined patients' perspectives and treated family support as one component of disease management (Endrias et al., 2024; Ghaderi Nasab et al., 2024). Research on resilience has more often involved chronic conditions with complex care needs and has rarely examined how family caregivers themselves develop adaptive capacity while managing hypertension in everyday life (Kuang et al., 2023). Consequently, existing evidence explains what families do and whether family-based interventions improve outcomes, but it provides limited insight into how caregiving stress, sociocultural pressures, emotional commitment, and unequal resources are negotiated into sustained caregiving.

This study addresses this gap by positioning one directly involved family caregiver from each family as the source of experiential data and by examining resilience as a process developed through hypertension caregiving rather than as a score measured using an instrument. The findings therefore represent caregivers' perceptions of caregiving within their family contexts, not a collective account from every member of each family. A phenomenological approach was used to understand the meaning of these experiences. Therefore, this study aimed to explore family caregivers' experiences of developing resilience while caring for a family member with hypertension.

METHODS

This study employed a descriptive phenomenological design because the approach enables an in-depth description of the meanings that participants attribute to a shared lived experience while remaining close to their accounts. It was considered appropriate for examining how family caregivers perceived, interpreted, and adapted to the demands of caring for a relative with hypertension. The study was conducted in the service area of Margadadi Community Health Center, Indramayu Regency, Indonesia, from May to August 2026.

Eleven family caregivers, each caring for a different patient with hypertension, were recruited purposively by the researchers. The researchers identified prospective participants who met the eligibility criteria and approached them directly. Eligible

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participants were aged at least 18 years, lived with or regularly interacted with the patient, had provided care for at least six months, could communicate effectively, and agreed to participate. One caregiver who was knowledgeable about and directly involved in care was selected from each family. Variation in age, sex, relationship to the patient, occupation, and duration of caregiving was sought to capture different caregiving circumstances.

The researchers served as the primary research instruments, supported by an audio recorder, an informant characteristics form, a semi-structured interview guide, field notes, and reflexive journals. The principal researcher conducted one face-to-face, in-depth interview with each participant at an agreed location. Core questions included: 'What has it been like to care for your family member with hypertension?', 'What difficulties have you encountered and how have you responded to them?', and 'What helps you continue providing care?' Probes explored changes in roles, coping, support resources, decision-making, and continuity of care. Each main interview lasted approximately 45–60 minutes and was audio-recorded with permission. Follow-up contact was used to clarify and validate the interpreted meanings when necessary. Field notes documented nonverbal responses, the interview context, and reflexive observations. Recordings were transcribed verbatim in Indonesian. The researchers translated selected quotations into English and cross-checked the translations against the Indonesian transcripts, considering grammar, contextual and cultural meaning, and participants' intended expressions to maintain semantic equivalence.

Data collection and analysis were conducted concurrently. After each interview, the researcher reviewed the transcript and recorded new information, recurring meanings, and emerging themes in a saturation monitoring table. Saturation was reached when subsequent interviews generated no new substantive meanings or themes and only reinforced previously identified patterns. The eleventh interview confirmed the stability of the themes; therefore, recruitment was discontinued.

Data were analyzed using Colaizzi's method (Colaizzi, 1978). Members of the research team repeatedly read the transcripts, identified significant statements, formulated meanings, and grouped related meanings into categories and themes. Preliminary interpretations were compared with the original transcripts and field notes. Differences in coding or interpretation were resolved through consensus discussions grounded in nursing and health knowledge and attentive consideration of the cultural meaning conveyed through participants' words, expressions, and observed responses. The team then developed an exhaustive description and returned interpreted meanings to participants during follow-up validation when clarification was required.

Trustworthiness was established through credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Credibility was supported by in-depth interviews, clarification of participants' responses, field notes, and member checking. Dependability and confirmability were maintained through reflexive journaling, documentation of the analytical process, and review of the themes by the research team. Transferability was supported by describing the participants, research setting, and relevant contextual characteristics and by presenting representative quotations.



For this study, caregiver resilience was operationalized as an ongoing adaptive process evident when participants recognized caregiving stressors, modified physical or emotional care, mobilized family and healthcare resources, negotiated sociocultural pressures, and maintained caregiving continuity despite burden or limited resources. Individual caregiving activities were interpreted as evidence of resilience only when participants' accounts connected those activities to adjustment, persistence, recovery from disruption, or sustained caregiving function.

Ethical approval was obtained from the Health Research Ethics Committee of Politeknik Negeri Indramayu (No. 09/PL42/KEPK-B/EC/2026). All participants received information about the study and provided written informed consent before data collection. Participation was voluntary, and participants could withdraw at any time. Their identities were anonymized using codes P1–P11, while recordings and transcripts were stored on password-protected media accessible only to the research team.

RESULTS

Eleven family caregivers caring for patients with hypertension participated in this study. Each participant was directly involved in care and described caregiving within the context of one family. Accordingly, the findings represent caregivers' individual perspectives on family caregiving processes rather than collective accounts from all members of each family. Participant characteristics included age, sex, relationship to the patient, educational level, occupation, and duration of caregiving (Table 1).



Table 1. Characteristics of the Participants

Informant	Age (years)	Sex	Relationship to the Patient	Education	Occupation	Duration of Caregiving
P1	18	Female	Child	Senior high school	Student	2 years
P2	55	Female	Wife	Bachelor's degree	Teacher	7 years
P3	32	Male	Child	Bachelor's degree	Private-sector employee	5 years
P4	25	Male	Child	Senior high school	Private-sector employee	2 years
P5	22	Female	Child	Senior high school	University student	3 years
P6	37	Female	Child	Junior high school	Homemaker	5 years
P7	52	Female	Wife	Primary school	Trader	8 years
P8	43	Female	Child	Senior high school	Trader	5 years
P9	28	Male	Child	Senior high school	Trader	4 years
P10	60	Male	Husband	Junior high school	Private-sector employee	8 years
P11	58	Female	Wife	Primary school	Homemaker	5 years

The participants were aged 18–60 years, with a mean age of 39.1 years. Seven participants were female and four were male. Most were the patients' children ($n = 7$), followed by wives ($n = 3$) and one husband. Educational levels ranged from primary school to a bachelor's degree, while the duration of caregiving ranged from 2 to 8 years, with a mean of 4.9 years.

The phenomenological analysis generated four themes describing how caregivers developed resilience through the demands of hypertension care. Resilience was not inferred from caregiving activities alone; it was identified in accounts showing that caregivers recognized disruption, modified their responses, mobilized resources, and maintained care over time. Experiences varied: some caregivers described confidence and shared routines, whereas others reported sadness, uncertainty about how to communicate, role overload, or feeling that their efforts were not recognized. The themes and subthemes are presented in Table 2.



Table 2. Themes and Subthemes of Family Caregivers' Experiences of Developing Resilience

No.	Themes	Subthemes
1	Reorganizing Care in Response to Hypertension-Related Threats	Learning from the threat of complications
		Adapting physical and emotional care
		Coordinating family care and healthcare services
2	Sustaining Care amid Social and Environmental Pressures	Responding to unexpected deterioration in the patient's condition
		Managing stressors beyond the family's control
		Negotiating social practices that undermine health
3	Transforming Affection into Adaptive Caregiving Commitment	Affection as a foundation for adaptive commitment
		Establishing shared healthy routines
		Maintaining control through active blood pressure monitoring
4	Maintaining Continuity of Care through Flexible yet Unequal Family Contributions	Bearing the unequal burden of proximity
		Adapting contributions according to distance and capacity
		Maintaining emotional and spiritual support

Theme 1. Reorganizing Care in Response to Hypertension-Related Threats

Learning from the Threat of Complications

Previous experiences of failing to recognize hypertension-related changes generated fear of stroke and the loss of a family member. These experiences became turning points that increased families' vigilance toward changes in the patient's condition and situations requiring professional assistance.

"I remember very clearly when Father began showing signs of a stroke. His face became slightly drooped, he could not speak, and he began losing consciousness. I do not want him to experience that again." (P4)

Adapting Physical and Emotional Care

Caregivers responded by reorganizing daily care, including preparing healthier meals, managing medication, monitoring the patient's condition, and avoiding conversations that might cause distress. The significance of these actions lay not merely in their performance but in how caregivers deliberately modified routines after recognizing the threat of complications.

"My mother always tries to prepare healthy food, such as boiled or steamed dishes. That makes it safer, and we avoid fried foods." (P3)



"We are always careful when choosing topics to discuss because we do not want Mother to worry. As much as possible, we, her children, try to resolve the problems ourselves because it would only add to her worries." (P5)

Coordinating Family Care and Healthcare Services

Caregiving extended beyond the home through accompaniment to medical appointments, referral arrangements, and communication with community health volunteers. These efforts connected home-based care with healthcare services and supported continuity of care.

"When it is time for a check-up, I usually accompany her to the doctor. Before that, I go to the community health center to obtain a referral letter. If she has any complaints or her blood pressure rises, I also inform the community health volunteer so that she can help arrange an examination." (P11)

Theme 2. Sustaining Care amid Social and Environmental Pressures

Responding to Unexpected Deterioration in the Patient's Condition

Unlike Theme 1, which describes changes prompted by the clinical threat of hypertension, this theme concerns disruptions originating in social relationships and circumstances beyond the caregiver's immediate control. Sudden deterioration created uncertainty and required caregivers to reassess the situation, regulate emotional responses, and adapt care without abandoning established routines.

"What worries us most is when his condition suddenly deteriorates. Sometimes he seems well, but after experiencing a problem or worrying about something outside the home, his blood pressure immediately rises. We then have to calm him down quickly and have his condition examined." (P6)

Managing Stressors beyond the Family's Control

Families faced external stressors that could destabilize the patient's condition despite their efforts to maintain care. Problems involving relatives or the surrounding environment could provoke worry, increase psychological stress, and affect blood pressure.

"We have tried to keep Father's condition stable, but sometimes he suddenly receives a telephone call from the extended family, asking or demanding something from him. He immediately becomes stressed and starts thinking about it too much. Situations like that eventually affect his blood pressure." (P7)

Negotiating Social Practices That Undermine Health

Social practices such as smoking, staying up late, and consuming fried foods challenged the lifestyle changes established at home. Rather than imposing strict restrictions, families repeatedly negotiated healthier choices while allowing patients to maintain their social relationships. This continuing negotiation demonstrates that family resilience required ongoing adaptation to influences that could not be fully controlled.

"When he gets together with his friends, they sometimes still invite him to smoke, stay up late, or eat fried foods, even though we have restricted these habits at home. We cannot be too strict with him, so we usually talk to him calmly and remind him again about how these habits affect his blood pressure." (P10)



Theme 3. Transforming Affection into Adaptive Caregiving Commitment

Affection as a Foundation for Adaptive Commitment

Affection did not constitute resilience by itself. It provided an emotional foundation from which caregivers sustained commitment, converted concern into repeated health practices, and continued adapting their care when routines became difficult. Participants differed in how secure they felt in this role; some described confidence, whereas others felt sad and uncertain about what to say because they feared worsening the patient's distress.

"We continue caring for her because we love her and want her condition to improve soon. If the family did not pay attention to her food, medication, and health, we would worry that her illness might become more severe." (P6)

"Sometimes I feel sad and confused about what to say to motivate the patient. I worry that the wrong words might make the patient even sadder." (P7)

Establishing Shared Healthy Routines

Families translated affection into shared healthy activities, particularly morning or weekend walks. Accompaniment increased the patient's willingness to exercise, supported physical health, and created a more positive caregiving experience.

"We try to make time to exercise together, usually by taking a morning walk. He is more willing to do it when someone accompanies him, so besides helping control his blood pressure, the activity also improves his mood." (P4)

Maintaining Control through Active Blood Pressure Monitoring

Regular blood pressure monitoring at community health centers, integrated health posts (posyandu), pharmacies, or at home helped families recognize changes and determine when professional assistance was needed. Monitoring therefore became a repeated expression of care and a means of maintaining control over the patient's condition.

"We routinely check her blood pressure every week, sometimes at the community health center, integrated health post, or pharmacy. If we do not have time to go out, we check it ourselves at home because it is one way for us to show our concern and look after her health." (P2)

Theme 4. Maintaining Continuity of Care through Flexible yet Unequal Family Contributions

Bearing the Unequal Burden of Proximity

Caregiving responsibilities were not distributed equally because family members differed in occupation, residence, and household obligations. Those living closest to the patient commonly became the primary caregivers. Their proximity maintained continuity of care, but it also concentrated practical, emotional, and financial demands. This tension demonstrates both adaptive continuity and the limits of flexible family contribution.

"Because I live closest to her, I provide most of her daily care, from managing her food to checking her blood pressure. My siblings actually want to help, but they work and live outside the city, so they cannot always be there to accompany her." (P10)



"I have tried my best, replacing his role as the breadwinner while also being a mother and a wife caring for him since he became ill. Even so, I am often considered uncaring or not attentive enough." (P2)

Adapting Contributions According to Distance and Capacity

Family members who could not be physically present continued to participate according to their capacity. Their contributions included treatment expenses, health insurance arrangements, supplements, and other health-related necessities. Thus, continuity of care was maintained through complementary rather than equally distributed responsibilities.

"The children who already have families of their own cannot always accompany her because they each have their own responsibilities. Even so, they still help arrange her health insurance, purchase supplements, or provide money when treatment expenses arise." (P5)

Maintaining Emotional and Spiritual Support

Family contributions also included encouragement, regular communication, and spiritual support. Encouraging patients to pray and draw closer to Allah helped sustain hope, calmness, and emotional closeness when family members could not be physically present.

"Although we cannot always accompany her in person, we still call her frequently and encourage her to continue looking after her health. We also remind her to pray often and draw closer to Allah so that she can feel more at peace." (P10)

DISCUSSION

This study shows that resilience among family caregivers of people with hypertension is a dynamic process rather than an automatic outcome of caring or a fixed attribute. Across the four themes, caregivers encountered clinical threats, social pressures, emotional uncertainty, and unequal responsibilities; they responded by modifying care, negotiating constraints, mobilizing resources, and maintaining caregiving continuity. Specific reminders, meal preparation, exercise, or blood pressure checks represented caregiving behaviors. They indicated resilience only when embedded in a broader process of learning, adjustment, persistence, and preservation of caregiving function. This distinction helps separate coping as a situational strategy, adaptation as the resulting adjustment, and resilience as the sustained process through which repeated coping and adaptation enable care to continue (Chi et al., 2024; Jin et al., 2023; Kuang et al., 2023).

The first theme indicates that previous failures to recognize hypertension-related changes and fear of stroke functioned as turning points. Caregivers did not simply add new tasks; they reinterpreted the illness threat and reorganized physical, emotional, and service-related care. Problem-focused coping was evident in medication, diet, monitoring, and referral actions; adaptation was evident in modified household routines; and resilience was reflected in the ability to sustain these adjustments over time. This interpretation extends evidence that hypertension management is influenced



by knowledge, perceived treatment benefits, family support, and access to care (Agyapomah et al., 2023; Eslamimehr et al., 2022; Woods et al., 2024).

The second theme highlights a different source of adversity: social and environmental pressures that caregivers could not fully control. Sudden changes in the patient's condition, stressful family communications, and social invitations to smoke, stay up late, or consume unhealthy foods repeatedly disrupted care. Caregivers' resilience was expressed through recalibration rather than complete control: they reassessed conditions, calmed patients, sought examinations, and negotiated healthier choices while preserving social relationships. Resilience therefore did not remove uncertainty; it enabled caregiving functions to continue when disruption occurred (Agyapomah et al., 2023; Durante et al., 2022; Muñoz-Cruz et al., 2024; Zhang et al., 2024).

Social invitations to smoke, stay up late, and consume fried foods illustrate that hypertension management occurs within social and cultural contexts that families cannot entirely control. Family members must repeatedly remind and supervise patients and negotiate healthier choices without disrupting their social relationships. This finding is important because hypertension management is not determined solely by individual knowledge. Group norms, peer influence, food culture, perceived behavioral control, economic circumstances, and access to healthcare services may either facilitate or hinder self-care practices (Eslamimehr et al., 2022; Woods et al., 2024; Yan & Insani, 2023). Therefore, family success should not be evaluated solely in terms of patient adherence but also according to the family's ability to establish realistic agreements and sustain behavioral changes amid environmental influences.

The third theme requires a distinction between motivation and resilience. Affection motivated caregivers to protect the patient, but adaptive resilience emerged only when that motivation was translated into sustained routines, monitoring, accompaniment, and revised communication. The accounts of sadness and uncertainty about offering encouragement also show that emotional closeness can increase vulnerability rather than uniformly strengthen coping. Affection therefore supported resilience through commitment and meaning-making, while practical knowledge, communication skills, and shared support were needed to convert commitment into sustainable care (Agyapomah et al., 2023; Kuang et al., 2023; Suwanwong & Raksat, 2025; Zhang et al., 2024).

Shared walking routines and blood pressure monitoring suggest that family resilience develops through simple and repeated health practices. Family accompaniment helped patients undertake lifestyle changes collectively, while monitoring enabled families to recognize changes and seek timely assistance. However, monitoring should be accompanied by an understanding of blood pressure readings, medication adherence, sodium restriction, physical activity, and communication with healthcare professionals. Family-based hypertension interventions should therefore extend beyond providing monitoring devices and strengthen self-management and patient-caregiver partnerships, which may improve adherence, relationship quality, and blood pressure control (Susanto et al., 2024; Woods et al., 2024; Zeng et al., 2024).



This interpretation is consistent with the positive relationship between resilience and self-care in chronic illness (Jin et al., 2023).

The fourth theme demonstrates that flexible contributions can preserve care while simultaneously concealing unequal burden. Family members living farther away contributed money, insurance arrangements, supplies, communication, or spiritual encouragement, but those living closest to the patient remained responsible for daily care. One caregiver's account of replacing the patient's breadwinning role while remaining a mother, wife, and caregiver illustrates role accumulation and lack of recognition. Flexible contribution therefore represented adaptive resource mobilization, but not necessarily equitable role sharing. Without assessment and respite, resilience may be mistaken for unlimited endurance and may coexist with emotional, occupational, and financial strain (Lima et al., 2023; Agyapomah et al., 2023; Muñoz-Cruz et al., 2024; Zhang et al., 2024).

Emotional and spiritual support complemented practical and material assistance. Encouraging patients to pray, draw closer to Allah, maintain a sense of calm, and preserve hope helped families find meaning in their caregiving experiences. In this context, spirituality did not replace medical treatment but served as a source of peace and endurance when families encountered uncertainty. Evidence involving families with long-term caregiving needs indicates that hope, spirituality, belief systems, and internal and external support contribute to the family adaptation process (Kuang et al., 2023). Spiritual intelligence has also been positively associated with family caregiver resilience, while psychosocial interventions, psychoeducation, and mindfulness-based approaches may strengthen resilience and reduce caregiver distress (Agyapomah et al., 2023; Muñoz-Cruz et al., 2024; Zhang et al., 2024).

The findings directly support nursing assessment of caregivers' recognition of deterioration, adaptive caregiving strategies, access to family and healthcare resources, and signs of concentrated burden. Nurses may use these findings to facilitate realistic role discussion, clarify blood pressure monitoring and referral decisions, and connect primary caregivers with available support. More structured interventions—such as resilience-based programs, digital monitoring systems, or multicomponent caregiver training—were not tested in this study and should be evaluated in future research before their effectiveness is assumed.

This study directly explored the experiences of 11 individual family caregivers and portrayed resilience as a process developed through everyday caregiving. The findings should therefore be interpreted as caregivers' perspectives within family contexts, not as collective family narratives. The single setting and absence of patients', other family members', community health volunteers', and nurses' perspectives limit transferability and triangulation. Future multisite studies should include patient-caregiver dyads or multiple members of each family and examine how resilience relates to caregiver burden, self-care, adherence, quality of life, and blood pressure control.



CONCLUSION

Resilience among family caregivers of people with hypertension developed through continuing adaptation to illness-related threats, social pressures, emotional uncertainty, and limited or unevenly distributed resources. The principal contribution of this study is showing that resilience was not the caregiving tasks themselves, but the process through which caregivers learned, reorganized care, negotiated disruption, mobilized support, and maintained caregiving despite burden. These findings are context-bound accounts from 11 caregivers and should not be interpreted as representing every member of their families. The findings highlight the importance of community nursing approaches that recognize adaptive caregiving capacity while also identifying unequal responsibility and primary caregiver burden.

IMPLICATIONS FOR NURSING PRACTICE

These findings support the inclusion of caregiver adaptation and burden assessment in community-based hypertension care. Nurses can assess how caregivers recognize deterioration, modify care, use internal and external resources, communicate with patients, and distribute responsibility. The findings also highlight opportunities for education about medication and dietary management, stress reduction, physical activity, blood pressure monitoring, and timely use of health services. The effectiveness of structured resilience programs, digital monitoring tools, or other multicomponent interventions should be tested in future studies rather than inferred from the present qualitative findings.

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ETHICAL STATEMENT AND CONFLICT OF INTEREST

Ethical approval was obtained from the Health Research Ethics Committee of Politeknik Negeri Indramayu (No. 09/PL42/KEPK-B/EC/2026). All participants received information about the study and provided written informed consent before data collection. Confidentiality and anonymity were maintained throughout the research process. The authors declare no conflict of interest.

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